

		FOR OHF USE					

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**2002**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2002)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION  
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY  
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE  
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE  
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL  
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM  
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<b>I. IDPH Facility ID Number:</b> <u>0018580</u>		<b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b>	
<b>Facility Name:</b> <u>Selfhelp Home of Chicago</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>10/01/2001</u> to <u>9/30/2002</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
<b>Address:</b> <u>908 W. Argyle Road</u> <u>Chicago</u> <u>60640</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
<b>County:</b> <u>Cook</u>		<b>Officer or Administrator of Provider</b> (Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) _____	
<b>Telephone Number:</b> <u>(773) 271-0300</u> <b>Fax #</b> <u>(773) 271-0633</u>		<b>Paid Preparer</b> (Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____ (Print Name and Title) _____ (Firm Name & Address) <u>Altschuler, Melvoin and Glasser, LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u> (Telephone) <u>(312) 634-3400</u> Fax # <u>(312) 634-5518</u>	
<b>IDPA ID Number:</b> <u>362521053001</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
<b>Date of Initial License for Current Owners:</b> <u>01/01/57</u>			
<b>Type of Ownership:</b>			
<input checked="" type="checkbox"/> <b>VOLUNTARY, NON-PROFIT</b>			
<input checked="" type="checkbox"/> Charitable Corp.			
<input type="checkbox"/> Trust			
<b>IRS Exemption Code</b> <u>501(c)(3)</u>			
<input type="checkbox"/> <b>PROPRIETARY</b>			
<input type="checkbox"/> Individual			
<input type="checkbox"/> Partnership			
<input type="checkbox"/> Corporation			
<input type="checkbox"/> "Sub-S" Corp.			
<input type="checkbox"/> Limited Liability Co.			
<input type="checkbox"/> Trust			
<input type="checkbox"/> Other _____			
<b>GOVERNMENTAL</b>			
<input type="checkbox"/> State			
<input type="checkbox"/> County			
<input type="checkbox"/> Other _____			
<b>In the event there are further questions about this report, please contact:</b> <b>Name:</b> <u>Charles J. Fischer</u> <b>Telephone Number:</b> <u>(312) 634-3400</u> <b>Please send copies of desk review and audit adjustments to address on this page</b>			

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Selfhelp Home of Chicago# 0018580 Report Period Beginning: 10/01/2001 Ending: 9/30/2002

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>30</u>	Skilled (SNF)	<u>30</u>	<u>10,950</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>35</u>	Intermediate (ICF)	<u>35</u>	<u>12,775</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>65</u>	TOTALS	<u>65</u>	<u>23,725</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>713</u>	<u>1,845</u>	<u>1,020</u>	<u>3,578</u>	8
9	SNF/PED					9
10	ICF	<u>4,578</u>	<u>13,345</u>		<u>17,923</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>5,291</u>	<u>15,190</u>	<u>1,020</u>	<u>21,501</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 90.63%

D. How many bed-hold days during this year were paid by Public Aid?

None (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?YES ☒NO ☐Non-allowable costs have been  
eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐NO ☒

I. On what date did you start providing long term care at this location?

Date started 01/01/57

J. Was the facility purchased or leased after January 1, 1978?

YES ☐Date N/ANO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒NO ☐

If YES, enter number

of beds certified 5 and days of care provided 1,020Medicare Intermediary Mutual of Omaha

## IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH\* ☐CASH\* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 9/30/2002 Fiscal Year: 9/30/2002

\* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Page 3

Facility Name &amp; ID Number Selfhelp Home of Chicago # 0018580 Report Period Beginning: 10/01/2001 Ending: 9/30/2002

## V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	260,397		11,602	271,999		271,999		271,999			1
2	Food Purchase		222,074		222,074		222,074	(4,534)	217,540			2
3	Housekeeping	94,482	21,171		115,653		115,653		115,653			3
4	Laundry		30,565		30,565		30,565		30,565			4
5	Heat and Other Utilities			65,885	65,885		65,885		65,885			5
6	Maintenance	52,859		63,700	116,559		116,559	46,299	162,858			6
7	Other (specify):*											7
8	<b>TOTAL General Services</b>	407,738	273,810	141,187	822,735		822,735	41,765	864,500			8
	<b>B. Health Care and Programs</b>											
9	Medical Director											9
10	Nursing and Medical Records	1,156,686	91,806	3,840	1,252,332		1,252,332		1,252,332			10
10a	Therapy			57,749	57,749		57,749		57,749			10a
11	Activities	112,653	7,820	2,218	122,691		122,691		122,691			11
12	Social Services			1,690	1,690		1,690		1,690			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	1,269,339	99,626	65,497	1,434,462		1,434,462		1,434,462			16
	<b>C. General Administration</b>											
17	Administrative	86,771			86,771		86,771		86,771			17
18	Directors Fees											18
19	Professional Services			30,242	30,242		30,242		30,242			19
20	Dues, Fees, Subscriptions & Promotions			7,327	7,327		7,327		7,327			20
21	Clerical & General Office Expenses	157,705	4,662	32,632	194,999		194,999	(8,718)	186,281			21
22	Employee Benefits & Payroll Taxes			310,018	310,018		310,018		310,018			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,300	2,300		2,300		2,300			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice											26
27	Other (specify):*											27
28	<b>TOTAL General Administration</b>	244,476	4,662	382,519	631,657		631,657	(8,718)	622,939			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,921,553	378,098	589,203	2,888,854		2,888,854	33,047	2,921,901			29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

\*\*See schedule of adjustments attached at end of cost report

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			75,836	75,836		75,836	31,889	107,725			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			54,180	54,180		54,180	(54,180)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			130,016	130,016		130,016	(22,291)	107,725			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		32,762	250	33,012		33,012		33,012			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops		209		209		209		209			41
42	Provider Participation Fee			35,587	35,587		35,587		35,587			42
43	Other (specify):* <b>Nonallowable Costs</b>	7,332		31,989	39,321		39,321	(39,321)				43
44	<b>TOTAL Special Cost Centers</b>	7,332	32,971	67,826	108,129		108,129	(39,321)	68,808			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,928,885	411,069	787,045	3,126,999		3,126,999	(28,565)	3,098,434			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

\*\*See schedule of adjustments attached at end of cost report

SEE ACCOUNTANTS' COMPILATION REPORT

	1	2	3	
	Amount	Refer-	OHF USE	
		ence	ONLY	
<b>NON-ALLOWABLE EXPENSES</b>				
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs				3
4 Non-Patient Meals	(4,534)	2		4
5 Telephone, TV & Radio in Resident Rooms				5
6 Rented Facility Space				6
7 Sale of Supplies to Non-Patients				7
8 Laundry for Non-Patients				8
9 Non-Straightline Depreciation	(66,754)	30		9
10 Interest and Other Investment Income				10
11 Discounts, Allowances, Rebates & Refunds				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax				13
14 Non-Care Related Interest				14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)				16
17 Non-Care Related Fees				17
18 Fines and Penalties				18
19 Entertainment				19
20 Contributions				20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainers				22
23 Malpractice Insurance for Individuals				23
24 Bad Debt				24
25 Fund Raising, Advertising and Promotional	(19,035)	43		25
Income Taxes and Illinois Personal				
26 Property Replacement Tax				26
27 Nurse Aide Training for Non-Employees				27
28 Yellow Page Advertising				28
29 Other-Attach Schedule See Schedule 5a	(29,004)			29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (119,327)		\$	30

OHF USE ONLY						
48		49		50		51
						52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
33 Amortization of Organization & Pre-Operating Expense			33
Adjustments for Related Organization			
34 Costs (Schedule VII)	90,762		34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$ 90,762		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B) )	\$ (28,565)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

	1	2	3	4	
	Yes	No	Amount	Reference	
38 Medically Necessary Transport.		X	\$		38
39					39
40 Gift and Coffee Shops		X			40
41 Barber and Beauty Shops		X			41
42 Laboratory and Radiology		X			42
43 Prescription Drugs		X			43
44 Exceptional Care Program		X			44
45 Other-Attach Schedule		X			45
46 Other-Attach Schedule		X			46
47 TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Selfhelp of Chicago, Inc. d/b/a The Selfhelp Home, Inc.

PROVIDER # 0018580

September 30, 2002

**Schedule 5A**

**VI. ADJUSTMENT DETAIL**

**NON-ALLOWABLE EXPENSES**

**LINE 29 - Other**

Description	Amount	Schedule V
		Reference
Disallow Outreach Program	(115)	43
Disallow Gift Shop Purchases	(7,489)	43
Disallow Marketing Salaries	(7,332)	43
Disallow Support Collateral	(550)	43
Disallow Part A Lab	(3,527)	43
Disallow Part A X-ray	(815)	43
Disallow Web Site	(458)	43
Miscellaneous Income Offset	<u>(8,718)</u>	21
<b>Total</b>	<b><u><u>(29,004)</u></u></b>	

**See Accountants' Compilation Report**

Facility Name & ID Number Selfhelp Home of Chicago# 0018580

Report Period Beginning:

10/01/2001

Ending:

9/30/2002

## VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				The Selfhelp Home, Inc.- Center Division	Chicago	Lessor

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES
 ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	6 Maintenance	\$	The Selfhelp Home, Inc.-Center Division	0.00%	\$ 46,299	\$ 46,299	1
2	V	30 Depreciation		The Selfhelp Home, Inc.-Center Division	0.00%	98,643	98,643	2
3	V	34 Rent	54,180	The Selfhelp Home, Inc.-Center Division	0.00%		(54,180)	3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 54,180			\$ 144,942	\$ * 90,762	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Selfhelp Home of Chicago # 0018580 Report Period Beginning: 10/01/2001 Ending: 9/30/2002

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3	See Attached Schedule 7A										3
4											4
5			No compensation or fees were paid to the Board of Directors								5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT



Selfhelp of Chicago, Inc. d/b/a The Selfhelp Home, Inc.

PROVIDER # 0018580

September 30, 2002

**Schedule 7A**

<b>Name</b>	<b>Title</b>	<b>Function</b>
Herbert Roth	President	Board Member
Rolf Weil	Imm. Past President	Board Member
Gerald Franks	First Vice-President	Board Member
Bernard Baum	Vice President	Board Member
M. Jay Heilbrunn	Vice President	Board Member
Austin Hirsch	Vice President	Board Member
Leni Weil	Treasurer	Board Member
Steven Loewenthal	Assistant Treasurer	Board Member
Henry Straus	Secretary	Board Member
Jack Bierig	Director	Board Member
Richard Eggener	Director	Board Member
Hanna Goldschmidt	Director	Board Member
Richard Greenthal	Director	Board Member
Robert Hoffmann	Director	Board Member
Suzanne Kach	Director	Board Member
Kurt B. Karmin	Director	Board Member
Martha Loewenthal	Director	Board Member
Margot Meyer	Director	Board Member
Stephen Nechtow	Director	Board Member
Barbara Passman	Director	Board Member
Michael Ries	Director	Board Member
George Rosenbaum	Director	Board Member
Marianne Weinberg	Director	Board Member
Daniel Wolf	Director	Board Member
Judith Wolf	Director	Board Member
Linda Liss Fine	Director of Resident Services	Board Member
Marvin Rubin	Director of Administrative Services	Board Member
Cathy Wolfson	Director of Community Relations	Board Member

**See Accountants' Compilation Report**

Facility Name & ID Number Selfhelp Home of Chicago# 0018580 Report Period Beginning: 10/01/2001 Ending: 0/30/2002

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number (\_\_\_\_) \_\_\_\_\_

Fax Number (\_\_\_\_) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13				N/A					13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Selfhelp Home of Chicago# 0018580

Report Period Beginning:

10/01/2001

Ending:

9/30/2002**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE****A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$					\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related						\$					\$	9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$					\$	14
15	TOTALS (line 9+line14)						\$					\$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # N/A

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
 (See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
 (See instructions.)

## B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.		\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	2
3. Under or (over) accrual (line 2 minus line 1).		\$	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ N/A	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.			
TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

1997

8

1998

9

1999

10

2000

11

2001

N/A

12

	FOR OHF USE ONLY	
13	FROM R. E. TAX STATEMENT FOR 2001 \$	13
14	PLUS APPEAL COST FROM LINE 5 \$	14
15	LESS REFUND FROM LINE 6 \$	15
16	AMOUNT TO USE FOR RATE CALCULATION \$	16

1. Please indicate a negative number by use of brackets ( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

**SEE ACCOUNTANTS' COMPILATION REPORT**

**IMPORTANT NOTICE**

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

**2001 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Selfhelp Home of Chicago COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0018580

CONTACT PERSON REGARDING THIS REPORT Mr. Marvin Rubin

TELEPHONE (773) 271-0300 FAX #: (773) 271-0633

**A. Summary of Real Estate Tax Costs**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
2. <u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
3. <u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
4. <u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
5. <u>                    </u>	<u>N/A</u>	\$ <u>                    </u>	\$ <u>                    </u>
6. <u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
7. <u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
8. <u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
9. <u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
10. <u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
<b>TOTALS</b>		\$ <u>                    </u>	\$ <u>                    </u>

**B. Real Estate Tax Cost Allocation:**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services?            YES            NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used)

**C. Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

## X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 73,944
 B. General Construction Type:
 Exterior
 Masonry
 Frame
 Steel
 Number of Stories
 3

C. Does the Operating Entity?
 (a) Own the Facility
 (X) (b) Rent from a Related Organization.
 (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 (X) (a) Own the Equipment
 (b) Rent equipment from a Related Organization.
 (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

The Selfhelp Home, Inc.; retirement facility; 94 apartments; square footage of 80,832

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 YES
 (X) NO
 If so, please complete the following:

1. Total Amount Incurred: N/A
 2. Number of Years Over Which it is Being Amortized: N/A
 3. Current Period Amortization: N/A
 4. Dates Incurred: N/A

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

## XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Resident Care	70,000	1970	\$ 191,769	1
2					2
3	TOTALS	70,000		\$ 191,769	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Selfhelp Home of Chicago

# 0018580

Report Period Beginning:

10/01/2001 Ending: 9/30/2002

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar**

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	65	1974	1974	\$ 822,760	\$	50	\$ 16,455	\$ 16,455	\$ 452,518
5									
6									
7									
8									
<b>Improvement Type**</b>									
9	Security System	1980		786		15			786
10	Security System	1981		29,527		15			29,527
11	Building Improvements	1981		808		20			808
12	Building Improvements	1982		2,642		15			2,642
13	Building Improvements	1983		2,717		10			2,717
14	Building Improvements	1986		1,212		10			1,212
15	Building Improvements	1987		3,000		10			3,000
16	Building Improvements	1988		6,752		10			6,752
17	Building Improvements	1989		30,538		10			30,538
18	Building Improvements	1990		10,425		10			10,425
19	Building Improvements	1991		9,690		10			9,690
20	Building Improvements	1992		22,014		10	1,104	1,104	22,014
21	Building Improvements	1992		932		7			932
22	Building Improvements	1993		14,166		10	1,417	1,417	13,126
23	Building Improvements	1993		183		7			183
24	Building Improvements	1994		27,620		10	2,762	2,762	23,477
25	Building Improvements	1994		3,836		5			3,836
26	Building Improvements	1994		5,148		7			5,148
27	Building Improvements	1995		18,411		10	1,841	1,841	13,808
28	Building Improvements	1995		363		7	25	25	363
29	Building Improvements	1995		176,882	8,844	20	8,844		66,330
30	Building Improvements	1995		15,209		5			15,209
31	Building Improvements	1994		33,000		5			33,000
32	Fence	1996		6,704	202	20	336	134	2,016
33	Decorating	1996		5,905	136	20	294	158	1,470
34	Blacktop Resurfacing	1996		1,646	50	20	82	32	492
35	Security Camera	1996		895	26	20	44	18	264
36									

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete

**See Page 12A, Line 70 for total**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Selfhelp Home of Chicago

# 0018580

Report Period Beginning:

10/01/2001

Ending:

9/30/2002

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar**

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Boiler repairs	1996	\$ 5,914	\$ 158	20	\$ 296	\$ 138	\$ 1,776	37	
38	Emergency call system	1996	14,557	58	20	728	670	4,368	38	
39	Cabinets & vanities	1997	2,938	34	20	147	113	864	39	
40	Fire Alarms	1997	12,818	486	20	641	155	3,603	40	
41	Elevator Improvements	1997	6,171	98	20	309	211	1,805	41	
42	Ceiling	1997	563		20	28	28	168	42	
43	Tubing and piping	1997	1,667	19	20	83	64	489	43	
44	Faucets	1997	999		20	50	50	300	44	
45	Flooring	1997	2,152	80	20	108	28	608	45	
46	Air Conditioning	1997	1,505		20	75	75	450	46	
47	Doors	1997	7,523	214	20	376	162	2,149	47	
48	Cement Work	1997	1,275	32	20	64	32	368	48	
49	Windows	1997	51,709		20	2,585	2,585	15,510	49	
50	Outdoor Sprinklers	1997	2,573	64	20	129	65	741	50	
51	Bathtub & Toilet	1997	605		20	30	30	180	51	
52	Tuckpointing	1997	4,583		20	229	229	1,374	52	
53	Blinds	1997	1,255	63	20	63		346	53	
54	Boiler	1997	1,097		20	55	55	330	54	
55	Office Refurbishing	1997	908	33	20	45	12	254	55	
56	Compressor and Base Board	1997	680		20	34	34	204	56	
57	Fire Alarms	1998	20,992	524	20	1,050	526	4,987	57	
58	Sound System	1998	862		20	43	43	595	58	
59	Architect	1998	43,360	2,112	20	2,168	56	9,783	59	
60	Windows	1998	4,588		20	229	229	1,145	60	
61	Lights	1998	1,517		20	76	76	380	61	
62	Kitchen Sink	1998	1,230	62	20	62		279	62	
63									63	
64									64	
65									65	
66									66	
67									67	
68									68	
69									69	
70	TOTAL (lines 4 thru 69)		\$ 1,447,812	\$ 13,295		\$ 42,907	\$ 29,612	\$ 805,339	70	

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete



**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,447,812	\$ 13,295		\$ 42,907	\$ 29,612	\$ 805,339	1
2	Doors & Locks	1998	685		20	34	34	170	2
3	Audio/Visual System	1998	10,578	264	20	529	265	2,513	3
4	Wall/Windows	1998	2,222	62	20	111	49	524	4
5	Cabinets & Vanities	1998	1,300		20	65	65	325	5
6	Electrical Work	1998	11,441	284	20	572	288	2,718	6
7	Heating & Cooling	1998	9,470	236	20	474	238	2,251	7
8	Roof	1998	8,333		20	417	417	2,085	8
9	Floor Coverings	1998	3,067		20	153	153	765	9
10	Computer Wiring	1998	6,242	312	20	312		1,404	10
11	Handrails & Grab Bars	1998	6,020	301	20	301		1,355	11
12	Lights	1999	1,217		20	60	60	210	12
13	Floor Coverings	1999	4,564		20	228	228	798	13
14	Heating & Cooling	1999	1,373		20	68	68	238	14
15	Elevator	1999	37,272	194	20	1,864	1,670	6,524	15
16	Cabinets	1999	2,251		20	112	112	392	16
17	Wall	1999	2,790		20	140	140	490	17
18	Fire Alarm	1999	14,911	658	20	746	88	2,611	18
19	Roof	1999	35,283	160	20	1,597	1,437	5,840	19
20	Call/Paging System	1999	5,142	164	20	258	94	903	20
21	Pipes & Faucet	1999	865		20	44	44	154	21
22	Room Conversion	1999	3,169		20	158	158	553	22
23	Fire Ducts	1999	35,113	1,756	20	1,756		6,146	23
24	Security System	1999	13,503	676	20	676		2,366	24
25	Electrical Wiring	1999	20,805	1,040	20	1,040		3,640	25
26	Architect	1999	540	28	20	28		98	26
27	Blinds	2000	1,050		20	53	53	159	27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,687,018	\$ 19,430		\$ 54,703	\$ 35,273	\$ 850,571	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete

## STATE OF ILLINOIS

Page 12C

Facility Name &amp; ID Number Selfhelp Home of Chicago

# 0018580

Report Period Beginning:

10/01/2001

Ending:

9/30/2002

## XI. OWNERSHIP COSTS (continued)

## B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 1,687,018	\$ 19,430		\$ 54,703	\$ 35,273	\$ 850,571	1
2	Cabinets	2000	3,135	23	20	134	111	402	2
3	Lobby Renovation	2000	3,397		20	170	170	510	3
4	Dining Room Renovation	2000	7,818	38	20	353	315	1,059	4
5	Washroom Renovation	2000	1,039		20	52	52	156	5
6	Light Fixtures	1999	893		20	45	45	135	6
7	Room Conversion	2000	673		20	34	34	102	7
8	Closet/Coat Room	2000	205		20	10	10	30	8
9	Doors	2000	1,568	5	20	73	68	219	9
10	Tiles	1999	140		20	7	7	21	10
11	Air Conditioner	2000	90		20	4	4	12	11
12	Resident Call System	2000	14,103	394	20	394		1,182	12
13	Heating & Cooling	2000	838		20	42	42	126	13
14	Ceiling Fan	1999	287		20	14	14	42	14
15	Dining Room Window	2001	1,834		20	92	92	138	15
16	Code Alert System	2001	2,501		20	125	125	187	16
17	Shower Temperature Control	2001	1,797	90	20	90		135	17
18	Call Station Living Room	2001	3,015	150	20	151	1	226	18
19	Doorknobs	2001	2,866		20	144	144	216	19
20	Repaving	2001	8,381		20	419	419	629	20
21	Fence	2001	784		20	40	40	60	21
22	Key Pad Locks	2001	776		20	39	39	58	22
23	Renovation of Kitchen, Basement & Elevator	2001	450,392	33,115	20	22,520	(10,595)	33,780	23
24	Elevator- Steel Frame	2001	533	27	20	13	(14)	13	24
25	Hot Water Tank	2001	2,070	49	20	52	3	52	25
26	Feed Pump	2001	2,300	115	20	58	(57)	58	26
27	Coils & Drains	2002	8,650	433	20	216	(217)	216	27
28	Boiler	2001	3,375	169	20	84	(85)	84	28
29	Carpeting	2002	28,345	709	20	709		709	29
30	Compressor	2002	3,375	169	20	84	(85)	84	30
31	Motorized Dampers	2002	18,547	464	20	464		464	31
32	Smoke Detectors and Duct Work	2002	9,644	241	20	241		241	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,270,389	\$ 55,621		\$ 81,576	\$ 25,955	\$ 891,917	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete

Facility Name &amp; ID Number Selfhelp Home of Chicago

# 0018580

Report Period Beginning:

10/01/2001

Ending:

9/30/2002

## XI. OWNERSHIP COSTS (continued)

## C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 398,904	\$ 19,920	\$ 25,854	\$ 5,934	5-7 years	\$ 221,976	71
72	Current Year Purchases	4,124	295	295		5-7 years	295	72
73	Fully Depreciated Assets	68,386				5-7 years	68,386	73
74								74
75	TOTALS	\$ 471,414	\$ 20,215	\$ 26,149	\$ 5,934		\$ 290,657	75

## D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

## E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,933,572	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 75,836	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 107,725	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 31,889	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,182,574	85

## F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

## G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

**1. Name of Party Holding Lease:** N/A

**2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?**

**If NO, see instructions.**

☐ YES      ☐ NO

**10. Effective dates of current rental agreement:**

## Beginning

## Ending

**11. Rent to be paid in future years under the current rental agreement:**

**8. List separately any amortization of lease expense included on page 4, line 34.**

This amount was calculated by dividing the total amount to be amortized by the length of the lease.

9. Option to Buy: ☐ YES ☐ NO Terms: \*

**15. Is Movable equipment rental included in building rental?**

**16. Rental Amount for movable equipment:** \$ **N/A**      **Description:**

**(Attach a schedule detailing the breakdown of movable equipment)**

Fiscal Year Ending	Annual Rent
--------------------	-------------

12.                      /2003 §

13.                      /2004 \$                     

14. \_\_\_\_\_ /2005 \$ \_\_\_\_\_

**\* If there is an option to buy the building, please provide complete details on attached schedule.**

**\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.**

**A. TYPE OF TRAINING PROGRAM** (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<b>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</b> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	<b>2. CLASSROOM PORTION:</b> IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	<b>3. CLINICAL PORTION:</b> IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
 (c) For in-house training programs only. Do not include fringe benefits.  
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training aides from other facilities.

\$ \_\_\_\_\_

**D. NUMBER OF AIDES TRAINED**

<b>COMPLETED</b>	
1. From this facility	
2. From other facilities (f)	
<b>DROP-OUTS</b>	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.  
**SEE ACCOUNTANTS' COMPILATION REPORT**

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L10A, C3	hrs	\$	1,832	\$ 17,468	\$	1,832	\$ 17,468	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		1	191		1	191	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		3,762	40,090		3,762	40,090	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescripts				29,999		29,999	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Schedule 16A				2	250	2,763	2	3,013	13
14	TOTAL			\$	5,597	\$ 57,999	\$ 32,762	5,597	\$ 90,761	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Selfhelp of Chicago, Inc. d/b/a The Selfhelp Home, Inc.

Provider #: 0018580

10/1/2001 to 9/30/2002

Schedule 16A

XIV. Special Services

Line 13 Other (Specify)

Service	Line Reference	Outside Units	Practitioner Cost	Supplies
Part A MCR Supplies	L39, C2			2763
Ambulance	L39, C3	2	250	
Total:			250	2763

See Accountants' Compilation Report

## STATE OF ILLINOIS

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Facility Name &amp; ID Number Selfhelp Home of Chicago

# 0018580

Report Period Beginning: 10/01/2001

Ending:

9/30/2002

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 9/30/2002

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 575,543	\$ 575,543	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 0 )	187,024	187,024	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	6,000	6,000	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Schedule 17A	105,376	105,376	9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 873,943	\$ 873,943	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		191,769	13
14	Buildings, at Historical Cost		822,760	14
15	Leasehold Improvements, at Historical Cost	1,163,474	1,447,629	15
16	Equipment, at Historical Cost	272,189	471,414	16
17	Accumulated Depreciation (book methods)	(457,214)	(1,182,574)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 978,449	\$ 1,750,998	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 1,852,392	\$ 2,624,941	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 40,032	\$ 40,032	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	43,151	43,151	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,050	3,050	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	See Schedule 17A	71,716	71,716	36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 157,949	\$ 157,949	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	See Schedule 17A	88,092	88,092	43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 88,092	\$ 88,092	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 246,041	\$ 246,041	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 1,606,351	\$ 2,378,900	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 1,852,392	\$ 2,624,941	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)



Selfhelp of Chicago, Inc. d/b/a The Selfhelp Home, Inc.  
 PROVIDER # 0018580  
 September 30, 2002

**Schedule 17A**

**XV. BALANCE SHEET -**

<b>Other Current Assets (specify):</b>	<b>After</b>	
	<b>Operating</b>	<b>Consolidation</b>
Bequest Receivable	103,500	103,500
Scholarship Loan Receivable	6,950	6,950
Scholarship Loan Payable	(5,074)	(5,074)
<b>Total Line 9 - Other Current Assets (specify):</b>	<b>105,376</b>	<b>105,376</b>

<b>Other Current Liabilities (specify):</b>	<b>After</b>	
	<b>Operating</b>	<b>Consolidation</b>
Deferred Retirement Plan	43,793	43,793
Current Maturity Retirement Plan	6,000	6,000
Accrued Expenses	21,923	21,923
<b>Total Line 36 - Other Current Liabilities (specify):</b>	<b>71,716</b>	<b>71,716</b>

<b>Other Long-Term Liabilities (specify):</b>	<b>After</b>	
	<b>Operating</b>	<b>Consolidation</b>
Interco A/C-Bonem Fund	28,182	28,182
Interco A/C-Scholarship	9,355	9,355
Interco A/C-Marx Fund	50,555	50,555
<b>Total Line 43 - Other Long-Term Liabilities (specify):</b>	<b>88,092</b>	<b>88,092</b>

See Accountants' Compilation Report

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,326,971	1
2	Restatements (describe):		2
3	Cumulative activity of funds other than healthcare facility	(1,041,474)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,285,497	6
	<b>A. Additions (deductions):</b>		
7	NET Income (Loss) (from page 19, line 43)	320,854	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 320,854	17
	<b>B. Transfers (Itemize):</b>		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,606,351	24 *

Operating Entity Only

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

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Facility Name &amp; ID Number Selfhelp Home of Chicago

# 0018580

Report Period Beginning: 10/01/2001

Ending: 9/30/2002

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

1			
	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 2,869,708	1
2	Discounts and Allowances for all Levels	(3,727)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,865,981	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	17,746	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	4,534	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	117,774	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 140,054	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions	416,677	24
25	Interest and Other Investment Income***	12,948	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 429,625	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Guest Apartment</b>	3,475	28
28a	<b>Miscellaneous Income (Offset against expense)</b>	8,718	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 12,193	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,447,853	30

2			
	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	822,735	31
32	Health Care	1,434,462	32
33	General Administration	631,657	33
	<b>B. Capital Expense</b>		
34	Ownership	130,016	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	72,542	35
36	Provider Participation Fee	35,587	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,126,999	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	320,854	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 320,854	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.  
Tax Exempt Organization

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name &amp; ID Number Selfhelp Home of Chicago

# 0018580

Report Period Beginning: 10/01/2001

Ending:

9/30/2002

## XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,000	2,080	\$ 72,108	\$ 34.67	1
2	Assistant Director of Nursing					2
3	Registered Nurses	17,522	19,563	384,732	19.67	3
4	Licensed Practical Nurses	5,869	6,534	107,454	16.45	4
5	Nurse Aides & Orderlies	60,183	67,746	592,392	8.74	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	6,690	7,396	112,653	15.23	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	2,063	2,590	32,491	12.54	13
14	Head Cook	5,571	7,481	81,259	10.86	14
15	Cook Helpers/Assistants	18,285	22,915	146,647	6.40	15
16	Dishwashers					16
17	Maintenance Workers	2,816	2,907	52,859	18.18	17
18	Housekeepers	11,617	13,287	94,482	7.11	18
19	Laundry					19
20	Administrator	1,030	1,030	59,797	58.06	20
21	Assistant Administrator	960	960	26,974	28.10	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,217	5,937	157,705	26.56	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Marketing	234	234	7,332	31.33	33
34	TOTAL (lines 1 - 33)	140,057	160,660	\$ 1,928,885 *	\$ 12.01	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

## B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	269	\$ 11,602	L1, C3	35
36	Medical Director				36
37	Medical Records Consultant	56	2,240	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,600	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	42	2,218	L11, C3	44
45	Social Service Consultant	35	1,690	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	402	\$ 19,350		49

## C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides		N/A		52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

## XIX. SUPPORT SCHEDULES

A. Administrative Salaries				Ownership		D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description		Amount	Description		Amount		
Linda Liss Fine	Administrator	0%	59,797	Workers' Compensation Insurance		39,860	IDPH License Fee				
Verna Segal	Asst. Admin	0%	26,974	Unemployment Compensation Insurance		4,227	Advertising: Employee Recruitment				
				FICA Taxes		149,559	Health Care Worker Background Check (Indicate # of checks performed 26 )		312		
				Employee Health Insurance		100,752	Life Services Network		3,310		
				Employee Meals			Illinois Council on Long-Term Care		3,705		
				Illinois Municipal Retirement Fund (IMRF)*							
				Retirement Plan		15,620					
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)											
B. Administrative - Other											
Description			Amount								
N/A											
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)											
C. Professional Services						TOTAL (agree to Schedule V, line 22, col.8)					
Vendor/Payee	Type		Amount	Description		Line #	Amount	G. Schedule of Travel and Seminar**			
Altschuler, Melvoin & Glasser LLP	Accounting		18,811					Description			
American Express TBS	Accounting		4,348					Amount			
Martin Brand	Accounting		1,453					Out-of-State Travel			
Paychex	Payroll		5,630	N/A				In-State Travel			
								Seminar Expense			
								2,300			
								Entertainment Expense			
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)				TOTAL				(agree to Sch. V, line 24, col. 8)			
								TOTAL			
								2,300			

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

**\*\*See instructions.**

Facility Name & ID Number Selfhelp Home of Chicago

STATE OF ILLINOIS

# 0018580

Report Period Beginning: 10/01/2001

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Ending: 9/30/2002

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. LSN \$3,310; IL Council \$3,705
- (3) Did the nursing home make political contributions or payments to a political organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 6 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 43,295 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 35,587  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 4,534
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? 0.00%  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
g. Does the facility transport residents to and from day training? N/A  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Altschuler, Melvoin & Glasser LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit Currently in Progress
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS** (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

Amount of Expense Amortized Per Year													
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11						N/A							
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

## RECONCILIATION REPORT

Selfhelp Home of Chicag

04:13 PM

11/04/05

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB- SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB- SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-28,565	equal to	-28,565	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	0	equal to	0	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	0	equal to	0	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	107,725	equal to	107,725	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	0	equal to	0	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	57,749	equal to	57,749	-1	FAILED	Pg16 Z12+Z14...	N/A/B	1-4,40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv.- Supplies	32,762	equal to	#VALUE!	#VALUE!	#VALUE!	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	822,735	equal to	822,735	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	1,434,462	equal to	1,434,462	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	631,657	equal to	631,657	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	130,016	equal to	130,016	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	72,542	equal to	72,542	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+†	N/A	38to41+43	4
Income Stat. Prov. Partic.	35,587	equal to	35,587	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	1,156,686	equal to	1,156,686	0	O.K.	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	112,653	equal to	112,653	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	0	equal to		0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	260,397	equal to	260,397	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	52,859	equal to	52,859	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	94,482	equal to	94,482	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	0	equal to		0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	86,771	equal to	86,771	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	157,705	equal to	157,705	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	1,928,885	equal to	1,928,885	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	11,602	< or = to	11,602	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	0	< or = to		0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	3,840	< or = to	3,840	0	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	2,218	< or = to	2,218	0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	1,690	< or = to	1,690	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	86,771	equal to	86,771	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other		equal to		0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	30,242	equal to	30,242	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	310,018	equal to	310,018	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	7,327	equal to	7,327	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	2,300	equal to	2,300	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	35,587	equal to	35,587	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	N/A	< or = to		0	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	N/A	equal to	0	#VALUE!	#VALUE!	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	1,020	equal to	1,020	0	O.K.	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	90,762	equal to	90,762	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4†	B.	14	8
Total loan balance	0	equal to	0	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	N/A	equal to		0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	191,769	equal to	191,769	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	2,270,389	equal to	2,270,389	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	471,414	equal to	471,414	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	1,182,574	equal to	1,182,574	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	1,606,351	equal to	1,606,351	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	320,854	equal to	320,854	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	1,852,392	equal to	1,852,392	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1



		Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustments	Adjusted Total
1. Dietary		260,397	0	11,602	271,999	0	271,999	0	271,999
2. Food Purchase		0	222,074	0	222,074	0	222,074	-4,534	217,540
3. Housekeeping-		94,482	21,171	0	115,653	0	115,653	0	115,653
	4	0	30,565	0	30,565	0	30,565	0	30,565
5. Heat and Other Utilities		0	0	65,885	65,885	0	65,885	0	65,885
6. Maintenance-		52,859	0	63,700	116,559	0	116,559	46,299	162,858
7. *		0	0	0	0	0	0	0	0
8. Total General Services		407,738	273,810	141,187	822,735	0	822,735	41,765	864,500
	9	0	0	0	0	0	0	0	0
10. Nursing & Medical Records-		1,156,686	91,806	3,840	1,252,332	0	1,252,332	0	1,252,332
10a. Therapy		0	0	57,749	57,749	0	57,749	0	57,749
11. Activities		112,653	7,820	2,218	122,691	0	122,691	0	122,691
	12	0	0	1,690	1,690	0	1,690	0	1,690
	13	0	0	0	0	0	0	0	0
	14	0	0	0	0	0	0	0	0
15. *		0	0	0	0	0	0	0	0
16. Total Health Care & Programs		1,269,339	99,626	65,497	1,434,462	0	1,434,462	0	1,434,462
17. Administrative-		86,771	0	0	86,771	0	86,771	0	86,771
	18	0	0	0	0	0	0	0	0
19. Professional Services		0	0	30,242	30,242	0	30,242	0	30,242
20. Fees, Subscriptions, & Promotio		0	0	7,327	7,327	0	7,327	0	7,327
21. Clerical & General Office-		157,705	4,662	32,632	194,999	0	194,999	-8,718	186,281
22. Employee Benefits & Payroll		0	0	310,018	310,018	0	310,018	0	310,018
	23	0	0	0	0	0	0	0	0
24. Travel & Seminar		0	0	2,300	2,300	0	2,300	0	2,300
	25	0	0	0	0	0	0	0	0
26. Insurance-Prop.Liab.Malpractice		0	0	0	0	0	0	0	0
27. *		0	0	0	0	0	0	0	0
28. Total General Adminis		244,476	4,662	382,519	631,657	0	631,657	-8,718	622,939
29. Total General Administrative		1,921,553	378,098	589,203	2,888,854	0	2,888,854	33,047	2,921,901
30. Depreciation		0	0	75,836	75,836	0	75,836	31,889	107,725
	31	0	0	0	0	0	0	0	0
32. Interest		0	0	0	0	0	0	0	0
	33	0	0	0	0	0	0	0	0
34. Rent-Facility & Grounds		0	0	54,180	54,180	0	54,180	-54,180	0
	35	0	0	0	0	0	0	0	0
	36	0	0	0	0	0	0	0	0
37. Total Ownership		0	0	130,016	130,016	0	130,016	-22,291	107,725
	38	0	0	0	0	0	0	0	0
39. Ancillary Service Cent		0	32,762	250	33,012	0	33,012	0	33,012
	40	0	0	0	0	0	0	0	0
	41	0	209	0	209	0	209	0	209
	42	0	0	35,587	35,587	0	35,587	0	35,587
43. Other (specify):-		7,332	0	31,989	39,321	0	39,321	-39,321	0
44. Total Special Cost Ce		7,332	32,971	67,826	108,129	0	108,129	-39,321	68,808
45. Grand Total		1,928,885	411,069	787,045	3,126,999	0	3,126,999	-28,565	3,098,434

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	575,543	575,543
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	187,024	187,024
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	0	0
7. Other Prepaid Expenses	6,000	6,000
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	105,376	105,376
10. Total current assets	873,943	873,943
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	0	191,769
14. Buildings, at Historical Cost	0	822,760
15. Leasehold Improvements, Historical Cost	1,163,474	1,447,629
16. Equipment, at Historical Cost	272,189	471,414
17. Accumulated Depreciation (book methods)	-457,214	-1,182,574
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	0
24. Total Long-Term Assets	978,449	1,750,998
25. Total Assets	1,852,392	2,624,941
CURRENT LIABILITIES		
26. Accounts Payable	40,032	40,032
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	43,151	43,151
31. Accrued Taxes Payable	3,050	3,050
32. Accrued Real Estate Taxes	0	0
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	71,716	71,716
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	157,949	157,949
LONG TERM LIABILITES		
39. Long-Term Notes Payable	0	0
40. Mortgage Payable	0	0
41. Bonds Payable	0	0
42. Deferred Compensation	0	0
43. Other Long-Term Liabilities (specify):	88,092	88,092
44. Other Long-Term Liabilities (specify):	0	0
45. Total Long-Term Liabilities	88,092	88,092
46. Total Liabilities	246,041	246,041
47. Total Equity	1,606,351	2,378,900
48. Total Liabilities and Equity	1,852,392	2,624,941

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	2,869,708
2. Discounts and Allowances for all Levels	-3,727
Subtotal - Inpatient Care	2,865,981
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	0
7. Oxygen	0
Subtotal - Ancillary Revenue	
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	
12. Gift and Coffee Shop	17,746
13. Barber and Beauty Care	0
14. Non-Patient Meals	4,534
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	0
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiology and X-Ray	0
21. Other Medical Services	117,774
22. Laundry	0
Subtotal - Other Operating Revenue	140,054
24. Contributions	416,677
25. Interest and Other Investments Income	12,948
Subtotal - Non-Operating Revenue	429,625
27. Other Revenue (specify):	12,193
28. Other Revenue (specify):	0
Subtotal - Other Revenue	12,193
30. Total Revenue	3,447,853
31. General Services	822,735
32. Health Care	1,434,462
33. General Administration	631,657
34. Ownership	130,016
35. Special Cost Centers	72,542
35. Provider Participation Fee	35,587
37. Other	0
40. Total Expenses	3,126,999
41. Income Before Income Taxes	320,854
42. Income Taxes	0
43. Net Income or Loss for the Year	320,854

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9 Line 16 for mortgage insurance.

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